BOARD OF REGISTRATION IN MEDICINE

Annual Report for Calendar Year 1979

Annual Report for Fiscal Year 1979

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Submitted by:

Claude E. Welch, M.D., Chairman
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APPROVED BY Alfred C. Holland, State Purchasing Agent

BOARD OF REGISTRATION IN MEDICINE

Annual Report for Fiscal Year 1979

and for Calendar Year 1979

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*Some of the tables in this annual report are based on Fiscal 1979 (July 1 to June 30), others on the calendar year. Please refer to title of each table for clarification.

ANNUAL REPORT FOR FISCAL YEAR 1979

AND FOR CALENDAR YEAR 1979

In compliance with General Laws Chap. 112, sec. 4.

1. Function and Purpose

General Laws Chap. 112, ss. 2 through 12R, sets forth the Activities of the Board of Registration in Medicine which include registration of physicians by examination or by endorsement, temporary registration of physicians; limited registration of interns, residents, fellows, medical officers; investigation of complaints, adjudicatory hearings, and disciplinary decisions. The Board also licenses physical therapists by examination or by endorsement. Other functions include verification of registrations for other states and for the Registry of Motor Vehicles, approval of affiliations between teaching hospitals, the initiation of legislation, review of proposed new legislation pertaining to the registration of physicians and to the practice of medicine and to disciplinary proceedings and hearings before the Board; approval of supervising relationship between a physician and physician assistant, maintenance of a registry of physicians who supervise acupuncturists and the implementation of continuing medical education requirements for reregistration in 1980. The Board also maintains a directory of all registrants; the information in it is updated biennially through reregistration of physicians and physical therapists.

2. Membership of the Board - General Laws Chap. 13, sec. 10.

Chapter 13 specifies that all members of the Board are appointed by the Governor for a three-year period. No member can serve for more than two consecutive full terms but is eligible for reappointment after a one-year interval. Members appointed for less than a full three-year term can serve in addition for the two full terms. A member serves until his successor is appointed.

The members of the Board on January 1, 1989, and their terms of appointment were as follows:

Members of the Board*	Date of Original Appointment	Date of Reappointment	Term Expires	Date of Appointment for First Full Term
George J. Annas, JD, MPH	Jan 1976	Dec 1978	1982	Jan 1979 (2)
Carl E. Cassidy, MD	Jan 1976	Sep 1977	Jan 1,1980	Sep 1977 (1)
Charlotte B. Cloutier, MA	Jan 1976	Sep 1977	Jan 1,1980	Sep 1977 (1)
Jeffrey E. Harris, MD	Mar 1978		1982	Jan 1979 (1)
James F. McDonough, MD	Nov 1979		1982	Jan 1982 (1)
Kathleen M. Mogul	Jul 1978		1981	Jul 1978 (1)
Claude E. Welch, MD	Jan 1976	Mar 1978	Jan 1,1981	Mar 1978 (1)

*Carl E. Cassidy, M.D., was reappointed to the Board on February 11, 1980. James F. McDonough, M.D., was appointed in November 1978 to replace Reginald Benn, whose term was to expire January 1, 1982. On January 11, 1980, Helen G. O'Meara was appointed to replace Charlotte B. Cloutier, M.A.

Officers of the Board for 1979 were elected on February 16. They were Claude E. Welch, M.D., Chairman; George J. Annas, J.D., M.P.H., Vice-Chairman; and Charlotte Cloutier, M.A., Secretary. The Complaint Committee was composed of George J. Annas, J.D., M.P.H., Chairman; Carl E. Cassidy, M.D.; Jeffrey E. Harris, M.D.; and Charlotte B. Cloutier, M.A. Other ad hoc committees were appointed during the year by the Chairman.

3. Meetings of the Board - General Laws Chap. 13, sec. 10.

The Board is required by statute to meet at least once a month. The Board met 17 times during 1979 on the dates shown in Table XII.

All Board meetings are open to the public except for executive sessions, which are held subject to the provisions of General Laws Chap. 30A, sec. 11A (2). In general, brief executive sessions are held at each meeting for the purpose of the disposition of disciplinary cases.

4. Legislative Acts 1979

In 1979 several laws were enacted that were important to the Board and to medical practice in Massachusetts. The most important ones are listed here. The Chapters all refer to the Acts of 1979.

Chapter 58

The name of the Board was changed from the Board of Registration and Discipline in Medicine to the Board of Registration in Medicine. The Board did not testify on this bill. It was sponsored by the Massachusetts Medical Society.

Chapter 214

This is a compilation of measures to protect patients' rights in hospitals and other facilities including all that are licensed by the Department of Mental Health. The most controversial section of this act involved the right of the patient "to complete information on all treatments which are medically viable" for cancer of the breast. The Board did not tesitfy on this bill. The writing of regulations concerned with this section was deferred until 1980.

Chapter 643

This law allows temporary registration for a period of not over three years for distinguished physicians from other countries to allow teaching or practice in this country. Furthermore, temporary registration of three months is provided for physicians licensed in other states to either practice or enroll in continuing medical education activities in Massachusetts. A somewhat similar bill had been introduced in 1978 by the Board.

Chapter 515

The Joint Underwriting Association received an extension to 1981. This bill was sponsored by the Commission on Malpractice. The Board approved this bill.

Chapter 674

This act changes the definition of clinics. By the new law the word "clinic" shall not include a medical office building or one or more practitioners engaged in a solo or group practice." This act removes these entities from regulation by the Department of Public Health. This bill may place more responsibility on the Board insofar as control of office procedures is concerned. This bill was sponsored by the Department of Public Health. The Board testified in favor of it.

The Board submitted several bills that were not approved by the Legislature in 1979. Nearly all of them were resubmitted in December of 1979 for consideration in 1980.

5. Licensure

a. Full Licensure

Full licenses are issued to physicians either by examination (i.e., FLEX) or by endorsement of a physician's certificate from the National Board of Medical Examiners of the United States, or the National Board of Examiners for Orthopedic Physicians and Surgeons or the American Osteopathic Association, or by endorsement of a license from another state, Puerto Rico or Canada. The Board granted full licenses to 1,404 physicians during fiscal year 1979; 780 were by endorsement of the National Board certificates, 287 by endorsement of licenses from other states, and 337 on the basis of the FLEX examination.

b. Specialty Licensure

The Board may grant licenses limited to the practice of a specialty to individuals who are certified by a Specialty Board but who have attempted to pass the FLEX examination but have failed. Such physicians, if they later pass the FLEX examination, may obtain a full license. The Board granted two such licenses (1 in radiology and 1 in pediatrics) in 1979. Six specialty licenses had been granted previously in 1978 and 1977.

c. Limited Licensure

Limited licenses are issued to enable physicians to complete their training before obtaining full licensure. These licenses allow the licensee to practice only in a specified health care facility. They are issued for a maximum of 5 years; any further extension is granted at the discretion of the Board. 1,927 limited licenses were issued in 1979; 8 were extended beyond the 5-year limit. The usual reason for extension was to allow preparation for further examination.

6. Examinations

The Board conducts two examinations for physicians and one for physiotherapists every year. In June and December the FLEX examination is given for physicians. For full licensure it is required that this examination be passed in one sitting with a weighted average of 75 or better. The examination is prepared by the National Board of Medical Examiners. Dr. Carl Cassidy, a member of the Board, serves as a member of their examination committee.

The results of these examinations are available a few months later. At the December 1978 examination the reports that reached us in February 1979 indicated that 152 individuals passed out of 313 who took the examinations (49%). The results were obtained in the office on February 2, 1979, and mailed to the examinees on February 14. At the

June 1979 examination 141 passed out of 287 (50%). In December 1979, 267 took the examination and 150 passed (56%).

The Board now requires that any individual who has failed three examinations must show evidence that he has taken further medical education before he can be enrolled for another examination. The Board also has increased the fees for the examination because of increased expense in preparation and physical arrangements for the examination. The cost of the FLEX examinations for FY 1979 was $8,977 for the examination rooms on Commonwealth Pier, $4,260 for the proctors, $46,334 for the examinations and additional amounts for office overhead (postage, clerk's time, etc.). Fees collected from applicants for the examinations totalled $78,200.

7. Reregistration

Reregistration of all physicians in the state on a biennial basis was first conducted in 1976. The second reregistration which was completed on January 15, 1978, was very difficult and engendered a great deal of controversy because of two factors. The first -- that a certified check be required for payment of the fee -- was eliminated by an emergency regulation of the Board. The second -- that all questions asked by the Board on the reregistration form be answered -- was modified so that answers to some questions were made optional.

In 1979 a great deal of attention was given by the Board to the design of a new form, with clear indications of which answers were to be required and which were to be optional for the 1980 reregistration cycle. Sample cards were prepared and tested by circulation to a random group of physicians, and after receiving their comments the final form was printed. Reregistration as an active physician for 1980 required (1) a check for $50, (2) filling out a form that contains 25 questions, 15 of which must be answered and 10 of which may be answered at the option of the physician, and (3) verification of continued medical education (CME) requirements or requests for waivers of CME. Data obtained from these forms will not be available until 1980. In December 1979 the entire process was proceeding smoothly but more slowly than either physicians or the Board would like.

For reregistration in 1980 the Board specified three types of licenses as follows:

a. Active physicians. Such physicians must send a completed reregistration form, evidence of continuing medical education (CME) and a check for $50.

b. Inactive physicians. Such physicians do not write prescriptions or practice medicine in Massachusetts. They are excused from

CME requirements; completed registration froms and a fee of $50 are required.

c. Retired physicians. No fee or CME is required.

The Board believes that all questions on the form are necessary because the public is entitled to have up-to-date information concerning each physician or is necessary for the proper function of the Board and particularly for its statutory mission to promote the public health. An opinion from the Attorney General's office has specified that all educational achievements of physicians must be public information. On the other hand, the Massachusetts Medical Society supported the concept that answers to some of the questions could be damaging to the registrants and advised against answers to the optional questions. It remains to see what percentage of physicians feel that their privacy is invaded by answers to the optional questions.

It should be noted that even in 1979 some physicians were surprised to learn that reregistration had been established by statute in 1975. This lapse has led to one disciplinary action and obviously could introduce legal problems for other licensees since it is the registrant's duty to reregister by January 15, 1980, and biennially thereafter.

The Board wishes to shorten the time between submission of an application for reregistration and issuance of the reregistration. Forms cannot be mailed until 60 days prior to January 15. The deluge of 16,000 to 18,000 applications, processing and computerization means that approximately six to eight weeks are required for the process. Hence, evidence of reregistration, except in unusual instances, will be in the physician's hands by March 15. The Board also approves of a triennial rather than biennial reregistration; most of the CME requirements, such as the Physician's Recognition Award of the AMA, are on a 3-year cycle.

Since this was the first year of implementation of requirements for CME, an enormous amount of correspondence was generated with physicians.

8. Reregistration Data - 1978

Some of the data obtained from reregistration forms in 1978 that have been prepared by the Data Processing Section for the Department of Registration include the following:

Total physicians registered		14,647	
Degree:	M.D.	13,873	
	D.O.	252	
	M.D. & D.O.	22	
	No answer	500	(presumed to be M.D.)

Residents and fellows	1,600
Specialty designation:	
Internal medicine	1,861
Pyschiatry	1,367
General surgery	906
Pediatrics	865
General practice	597
Family practice	534
Board certified	53%

533 physicians were defendants in a malpractice suit

486 physicians had their hospital privileges restricted

29 physicians were both defendants in a malpractice suit and had hospital privileges restricted

Thus, 3.6% of licensed physicians were defendants in a malpractice suit during the years 1976-1977. This is an incidence of 1.8% per year and indicates one suit per 55 years of practice. Though this incidence is low, the mere fact that there were so many suits shows that the malpractice problem is not completely solved.

Restriction of hospital privileges probably was attributable on the part of older physicians to age limits, although the Board did not ask the reason for restrictions. It would be expected that the combination of a malpractice suit and loss of hospital privileges might indicate more serious problems; there were only 29 individuals in this group.

Because the filing of a malpractice suit does not prove guilt, for the 1980 reregistration form the Board changed the phrasing of the question of malpractice to "Has a final judgment been returned against you in a malpractice suit in 1978 ot 1979?"

9. Requests for Information

The Board has in its files information provided by all registrants at the time of their initial registration. In addition, other data are gathered at the time of reregistration to update the previous material. Since reregistration information is computerized there has been considerable debate concerning the confidentiality of such data particularly since the computer used by the Board is controlled by the Department of Public Health. The Board has entered into agreement with the DPH that all this material is the property of the Board. The Board also has considered the questions that it asks on its reregistration form

and has made answers optional for a number of the questions that conceivably could violate privacy. Data acquired from answers to the required questions on the registration form must be released by public information laws to any person who requests. However, the Board specifies that only aggregate data will be released from answers to optional questions. The cost to the inquirer who wishes a complete print-out of all physicians in the state is approximately $50. During the year approximately 30 requests have been approved. Several others were denied because specific personal data were requested.

It must be emphasized that the public information act allows access by the public to all files of the Board (except for interoffice memoranda that occasionally are necessary) in cases still under investigation. Access of the public to investigatory material in the Board file is unique to Massachusetts. It is apparent that the system is difficult to administer, and hopefully a better one can be devised and established by statute. At present requirements for such information are logged; a 2-week waiting period is enforced in order that any information on cases still under investigation that has been submitted to the Board as confidential is kept in a confidential file; the presence of such material is noted in the public file. Incidentally, the Board has received very few requests for such information. After a complaint has been closed the action of the Board and supporting material are open to the public.

10. Continuing Medical Education

The Board in 1976 adopted a regulation that evidence of continuing medical education would be required for reregistration in 1980. A great deal of time was spent in 1979 in preparation for the activation of this requirement.

Undoubtedly the medical profession has an implicit belief in the value of CME, even though dispute continues concerning the ability of the physician to apply knowledge gained in this way. Acceptance of this concept by physicians is evidenced by the fact that there has been no court challenge to this regulation by the Board even though it is not established by statute.

The ramifications of documentation are not easy. They have not been made any simpler by the split between the two national bodies devoted to this cause -- the AMA and the Liaison Committee for Continuing Medical Education. At the present time these two organizations are engaged in a struggle to determine which or both will set standards or accredit local agencies or hospitals to give such education. In addition, there are many elder physicians who carry on very limited practices and have requested approval of individual programs or excuse because of illnesses.

By January 1, 1980, submission of data concerning CME was proceeding

smoothly. A complete breakdown of the methods by which approval of CME had been obtained will not be available until after January 15, 1980. The Board has specified six ways to fulfill the CME requirements. The Massachusetts Medical Society has made evidence of CME a requirement for membership and plans to accept decisions of the Board concerning adequate documentation. It is planned that the Board will check the records of random physicians in 1980 and ask for complete documentation in certain instances to be sure that the reports have been correct.

Insofar as CME is concerned, the Board has specified that a waiver of these requirements may be granted on the basis of documentation of illness, absence from the country, evidence of an individual program deemed satisfactory by the Board, unavailability of CME activities, or inactive status of the physician (i.e., he does not see patients or write prescriptions).

11. Affiliations

The Board approved 20 affiliations between health facilities and/or post-graduate training programs in 1978. The Board is making every attempt to be certain these affiliations are approved by organizations such as the Residency Review Committees composed of joint representatives of the AMA and Specialty Societies and listed in the Approved Residency Directory published by the AMA.

A relatively new feature of the affiliations is occurring in family practice. "On-site" training has led to assignment of many of these residents to individual physicians' offices. Some of these offices may have little connection with the parent center. There are obvious opportunities for abuse in the present system. In general, the Board cannot conduct individual investigations of these affiliations but must accept the recommendations of other certifying organizations.

12. Disciplinary Actions

Disciplinary actions by the Board are initiated by complaints that may be submitted by any person to the Board. All cases first are investigated by the Complaint Committee (George Annas, J.D., Chairman), or, if the Board does not have jurisdiction, referred to some other agency.

In FY 1979 the Board considered 316 complaints. After processing, 134 others were not docketed but were referred to other agencies or boards; a breakdown of these complaints is shown in Table I A. Docketed complaints in FY 1979 totaled 182, of which 111 have been closed and 71 were still pending as of January 1, 1980 (Table I B.) However,

because 133 complaints that has been received prior to 1979 still had not been resolved, there was a total of 152 docketed complaints pending on 6/30/79. Thus the Complaint Committee considered 439 complaints in FY 1979 and closed 287.

The figures for complaints docketed in calendar year 1979 are not greatly different (Table 1 C.). A total of 162 complaints were docketed; 103 were closed and 58 are still pending. The great majority of these complaints are decided in favor of the physician, although in some cases an admonitory letter is sent as well.

Complaints that cannot be resolved by the Complaint Committee are referred to the Board. In the cases that cannot be resolved by the Board without further action, an Order to Show Cause is given and full legal proceedings are instituted.

Determination of Disciplinary Cases

Calendar Year 1979

During the calendar year 1979 the Board completed and issued final orders on 10 disciplinary cases (Table III). Of this group the final disposition was as follows:

Revocation	Lozano, Gauthier, London, Arthur (Arthur stayed by Board until court transcripts are available)
Suspension	Kobrowsky (stayed by Board pending appeal)
Censure	Hammer
Dismissal of charges	Harken, Shapiro
Order withdrawn	Jordan
Resignation	McCarthy

Revocation of license was carried out in 3 cases on drug charges and 1 for fraud. The average length of time between filing of a complaint and final decision was 25 months.

Compared with the former calendar year in 1978, the Board disposed of only 10 Orders to Show Cause in 1979 compared with 23 in 1978. This significant decrease was due to the loss of an executive secretary who also served as prosecuting attorney. The Board also had expected to have a Counsel IV and a Counsel II in its employ during the last half of 1979. Funds for these positions had been voted by the Legislature, but despite repeated attempts by members of the Board the positions never were released. At present the only attorney in the office is hired as an investigator.

The case of the Board vs. Cardio-Thoracic Associates has proved to be important, but long and costly. An Order to Show Cause was given on 12/20/77, and Charles Baron, J.D., was appointed as hearing officer. The case will probably go to trial in March 1980. Due to the complexity and serious nature of the case the Board hired the firm of Choate, Hall and Stewart as prosecutors.

The status of pending disciplinary cases is shown in Table IV. As of 1/1/79 there were 23 cases pending in which an Order to Show Cause had been sent; on 12/31/79 there were 27 cases pending.

13. Finances and Budget

The receipts and expenditures of the Board for FY 1979 in comparison with the previous year are shown in Tables VII, VIII and IX.

The actual expenditures in 1979 for the subsidiary accounts were as follows:

01	Board members salary	19,800
02	Other salaried positions	9,374
03	Consultants (physicians, lawyers, examination proctors)	50,750
10	Travel for Board members	4,700
11	Printing	
12	Repairs	
13	Examinations (FLEX, physiotherapy)	
14	Office supplies, membership dues, postage, telephone	9,097
15	Equipment	
16	Rental (space for examinations, IBM typewriters, Xerox, dictaphone	6,840

In addition, many of the remaining expenses such as salaries of clerks, rental of examination space, etc, were paid by the Department of Registration. This amounted to $187,111, so that the total expenses of the Board amounted to $287,672. Departmental revenue accounted for $227,793, so that the net loss to the State was $59,879. (See Table XI.

The budget for 1981 as submitted by the Board and that which was recommended by the Secretary of Consumer Affairs and the Governor are shown in Table X. The major variations of the Board's budget and the Secretarial recommendation are as follows

a. The Board requested 2 counsels for its disciplinary activities. The Secretary transferred this request to the Division of Registration for combined use by the 22 Boards.

b. The Secretary recommended an executive secretary for the Board.

c. The Secretary reduced expenses for stenographic and legal consultants.

d. The Board's request for additional office space was denied.

The total expenditures of the Board in 1979 together with the projections for five future years are shown in Table XI.

14. Amendments to Rules and Regulations

The Board held two public hearings in conjunction with the Board of Nursing on the prospective regulations for nurses practicing in the expanded role.

15. Important Judicial Decisions

Not unexpectedly, nearly all of the Board's decisions that have led to disciplinary actions have been appealed to the courts. At the present time all of the Board's decisions have been sustained by the courts, but the legal process often has been long and expensive and has required strenuous efforts by our legal staff. These briefs have been written by or under the direction of Attorney Garrick W. Cole, Assistant Attorney General, and by Attorney Paul Brown, Assistant Attorney General.

A decision by Justice Abrams of the Supreme Judicial Court that is of particular interest was rendered in the matter of Levy vs. the Board. The Board had revoked the license of Dr. Levy because of convicted fraud in the management of nursing homes. Levy argued that this conviction had nothing to do with his ability to practice medicine. Justice Abrams, sustaining the Board's action, made many comments. This very important decision was described by Richard Gibbs, a member of the Special Malpractice Commission, in Legal Aspects of Medical Practice 7:23 (Nov.) 1979. Since this decision was of so much importance, excerpts from his paper will be quoted.

"Dr. David A. Levy was a highly successful general practitioner. He owned and operated 11 nursing homes, but an investigation by the Massachusetts Department of Public Welfare led to allegations that Dr. Levy had grossly overcharged for physician and related health care services for welfare recipients and that he had submitted fraudulent claims for reimbursement. The Commonwealth of Massachusetts took Dr. Levy to court, and he pleaded guilty. The court ordered Dr. Levy to pay restitution totalling nearly $314,000 to the Department of Public Welfare. In addition, he was fined over $32,000 and given a two-year suspended sentence. Because the licensee of a nursing home in Massachusetts must be of 'good moral character,' Dr. Levy's license to operate nursing homes was revoked.

"That was not the end of the matter. Shortly after his convictions, Dr. Levy received an order from the Massachusetts Board of Registration and Discipline in Medicine to 'show cause why' his certificate of registration in medicine should not be revoked, suspended, or cancelled. The show cause order listed his recent criminal convictions. Only two issues were to be considered.

1. The authority of the board to impose any sanctions in this matter.

2. An appropriate sanction to be imposed by the board.

"In its consideration of Dr. Levy's case, the board observed full procedural and due process. The board concluded that 'the crimes to which the defendant pleaded guilty are serious offenses against statutes closely related to the practice of medicine.' In other words, the board concluded it had authority to impose sanctions in this instance. And it went on to do so by revoking Dr. Levy's Massachusetts medical license.

"Dr. Levy applied for judicial review of the board's decision. On July 26, 1979, the Supreme Judicial Court of the Commonwealth of Massachusetts handed down an opinion in the case of David A. Levy v. Board of Registration and Discipline in Medicine [Docket No. S-1697]. In an order having far-reaching implications, the court affirmed the board's findings and its order revoking Dr. Levy's license. In doing so, the highest court in Massachusetts held:

1. The Board of Registration and Discipline in Medicine has jurisdiction to make conviction of a crime a ground for discipline.

2. The board has the statutory authority to act upon such crimes as are closely related to the practice of medicine.

"In the past, insurance carriers and other third parties paying for medical care have been loathe to prosecute physicians who submitted fraudulent claims for service. In Massachusetts, the ruling in the

case of Dr. Levy can change all this. Now, the carriers need only file a complaint with the Board of Registration and Discipline in Medicine alleging insurance fraud. If the allegations are found to be true, the board could revoke or suspend the physician's license to practice medicine.

"Having lost all his arguments before the court, Dr. Levy made a final try for a less onerous punishment. He asked the court to reduce the severity of the sanction imposed by the board to probation rather than revocation, asserting he had been punished enough for his crimes. The court denied his plea. It pointed out that revocation is not designed to punish the physician but to protect the public health and safety.

"The court's decision took a moralistic turn. 'Mere intellectual power and scientific achievement without uprightness of character may be more harmful than ignornance. Highly trained intelligence combined with disregard of the fundamental virtues is a menace,' the court said. It added that 'the public has the right to expect the highest degree of integrity from members of the medical profession.'

"And physicians, the court observed, deserve protection from guilt by association with fraudulent conduct that reflects unfavorably on the medical profession. The legislature, the court said, gave the board authority not only to protect the public but also 'the vast majority of physicians in the community, who do possess the highest degree of integrity, and who ought not to have public esteem for their honorable and learned profession eroded by a few who do not live up to the solemn nature of their public trust."

16. Nurses Practicing in the Expanded Role

In 1975 the Board of Nursing was directed by Chapter 846 of the Acts of 1975 to draw up rules and regulations for nurses practicing in the expanded role. The approval of the Board of Medicine was required for adoption.

This task was a formidable one because it epitomized the desire of nurses to expand their activities into a domain that is essentially the practice of medicine, and, on the other hand, antagonized many physicians who saw any such action as an invasion of the roles traditionally reserved for physicians.

The Boards held numerous meetings, both singly and together, and two public hearings. An enormous mass of testimony was obtained. The final document was finally prepared by our attorneys and was approved by both Boards in December 1979. (The final document was published in January 1980 and is available as Publication no. 11697-14-1000-1-80-C.R. Also see 244. C.M.R.: Board of Registration in Nursing 244 C.M. 4.00.)

The purpose of the regulations was to establish the conditions under which nurses who are registered with the Board of Registration in Nursing may practice in the expanded role and to establish principles of supervision, responsibility and discipline to which nurses practicing in the expanded role, their supervisors, collaborators and employers are subject.

The thrusts of the new regulations are (1) to specify four types of nurses practicing in the expanded role (nurse anesthetists, nurse midwives, psychiatric nurse mental health clinical specialists, and nurse practitioners); (2) to specify their educational requirements, and (3) to identify the relationships with doctors who act as supervisors or collaborators. The guidelines specify that written protocols covering the activities of these nurses shall be available as required for inspection by the Board of Nurses and in the instance of nurse practioners by the Board of Medicine. A liaison committee has been established by the Boards to maintain constant vigilance.

The final rules and regulations will be regarded as too radical a departure from established custom by many observers and too conservative an approach by others. The Boards believe this document reflects the present situation in many model health facilities and one that will prevent unlimited freedom of action by nurse registrants.

17. Medical Malpractice

Chapter 372 of the Acts of 1975 established three entities -- the Joint Underwriting Association, medical tribunals and a new Board of Registration and Discipline in Medicine; among other provisions, stricter controls on medical practice were established.

The annual report of the Special Commission on Medical Professional Liability Insurance for the year 1978 was published on June 12, 1979. This report noted that the crisis in medical malpractice has passed. This is evidenced by a 6% reduction in the total premium volume of the Joint Underwriting Association in 1979 compared with 1978. In addition, substantial reductions were paid to physicians who purchased claims-made coverage from the JUA in previous years.

In 1978 the JUA provided malpractice coverage for an average of 9,840 physicians and 125 hospitals. In this year 295 claims were filed against physicians and 372 against hospitals. A total of 372 claims were closed in the year.

One hundred and three JUA cases were heard by malpractice tribunals; 55 were decided for the plaintiff and 48 for the defendant health care provider. Since inception of the tribunals, between 189 and 242 cases (33 to 42%) of the total medical case load) have been excluded from

the court system. Of a total of 575 tribunals held, 261 were decided in favor of the defendant, so that a bond had to be filed by the plaintiff if further court action was to be pursued; such a bond was filed in 72 cases.

The Board of Registration in Medicine is the third important body described in Chapter 362. The Commission's report quotes an audit made of the Board by Mark D. Abrahams, Assistant to the Comptroller in 1978. This report stressed the necessity of improved methods of record keeping and clerical administration, uncertainties about budgeting and hiring personnel, and an ill-defined relationship to the Division of Registration. The report of the Commission in June 1979 stated:

"The Board of Registration in Medicine has assumed a very important role in the health care system of Massachusetts through its licensing and regulatory activities. Having overcome initial funding and organizational difficulties, the Board has succeeded in adopting a wide-ranging and forceful set of rules and regulations governing the practice of medicine and has undertaken vigorous enforcement of them."

The Board wishes to thank the members of the Commission and the Chairman, Seantor Daniel Foley, for their strong support both in administrative matters and in funding, and for the presence of one of the Commission members, Dr. Richard Gibbs, at some of the meetings of the Board.

18. Other Organizations that Impact Upon the Board

The Board's activities are influenced by many other State and Federal agencies. Some of these relationships have been discussed above; several others require mention.

a. Division of Registration and Secretary of Consumer Affairs

The Board of Registration in Medicine is directly responsible to the Division of Registration which is an administrative agency for 22 boards. The Division is directly responsible to the Secretary of Consumer Affairs.

Staffing for the office of the Board is complex. At the outset of 1979 the Board had an executive secretary. Because of the resignation of the Executive Secretary Attorney Chris Stern (who moved to New York City), the post of Executive Secretary was vacated in February 1979. The Board had anticipated that 4 additional positions (Counsel IV, Counsel II, and 2 Chief Clerks) would be released a few months later since funds had been approved in the FY 1980 budget and authorized by the Legislature; this increase in personnel could then have allowed the duties of the Executive Secretary to be assumed by others.

However, none of the 4 positions were released in 1979 despite the efforts of Board members. In December 1979 the Board was notified that the Secretary had approved the positions of an Executive Secretary and 2 Investigators to be appointed by the Board rather than by the Division of Registration.

As of January 1, 1980, staffing for the office of the Board continues to be complex. At the present time the Board has authorized positions as follows: 1 Executive Secretary, 2 Investigators, and 1 Clerk. The 5 other office clerks are employees of the Division of Registration. These clerks can be withdrawn and assigned to other boards without the knowledge or approval of the Board of Medicine. This had led in the past to serious dislocations in our office work.

The Board is certain that the operation of the office could be made much more efficient if it controlled all the personnel in the office. The backlog of work is so great that it is inconceivable that our skeleton staff will not be continuously occupied. Any reduction beyond our control can have serious consequences.

b. Department of Public Health

The Department of Public Health spent a great deal of time in 1979 revising rules and regulations that relate to clinics. The important statutory change -- that clinics do not include individuals or groups of doctors (unless they are designated as clinics) -- was accepted with the approval of the Board. Other rules and regulations have been discussed frequently in ad hoc groups and will be further defined in a public hearing in 1980.

c. Department of Public Welfare

The Department of Public Welfare has had no direct contact with the Board during the year. However, the Federal requirement that all hospitals that have received Hill-Burton funds must provide care for the indigent has tended to increase available medical care for Medicaid recipients. The Board has received only 3 complaints in 1979 from persons saying that they have been refused care because they are Medicaid patients. On the other hand, many physicians do not see such patients but refer them to hospital ambulatory clinics. The Board in its regulations requires that all physicians must provide emergency care to any person needing it. On the other hand, extension of this principle to individuals without illnesses that require emergency care infringes upon the right of a physician as an individual to choose whom he wishes to treat. There are several obvious solutions of which the most important would be to have a unform fee system for all Medicaid and Medicare patients. At the present date this has not been implemented at the federal or state level.

d. Federal Legislation

The most important regulation affecting physicians has been included in PL 96-79 (the Health Planning Act). One of the regulations includes the requirement that a certificate of need is required for any expenditure of over $150,000 for any expense incurred in a private office. This requirement is primarily devoted to preventing proliferation of computerized body scanners.

e. Health Service Agencies

Health service agencies gradually are increasing their powers. HSA IV for Massachusetts includes the Boston metropolitan area. In the final report in 1979 there is no mention of any impact of the Board on health planning.

f. Legislature

The Legislature has been extremely responsive to requests of the Board for adequate funding. In July 1979 the Legislature approved the Board's budget that included funds for four additional positions including 2 attorneys and 2 chief clerks; unfortunately, as of December 30 these positions still had not been released. The Legislature also approved an additional request for legal expenses of approximately $100,000 incurred in prosecution of the Malden Hospital case.

g. Special Commission on Malpractice

The Special Commission on Malpractice receives reports from the Board of Registration and monitors the activities of the Board.

h. Commissioner of Insurance

An additional duty of the Board is to provide members to sit with a special board which reviews disputes by Blue Shield vs. participating physicians. These boards are composed of three members -- one appointed by the Insurance Commissioner, one by the Attorney General and one by the Chairman of the Board of Registration in Medicine. At the present time 6 such complaints are under active consideration.

19. National Meetings, Conferences, Etc.

The Board sent representatives in 1979 to the annual meetings of the Federation of State Medical Boards, to the Council on Medical Specialty Societies, the Alliance for Continuing Medical Education, and a National Conference on the Impaired Physician. Important items of concern in these meetings included continuing medical education, licensure

examinations, mechanisms of board administration, and treatment of the impaired physician. One of our members (Dr. Cassidy) serves on the examination committee of the National Board of Medical Examiners that prepares examination questions for FLEX.

Attorney Annas has been a frequent contributor to Hastings Center reports on medicolegal matters. This foundation is the preeminent organization in the United States that deals with morals and ethics as they interface with medicine, law and economics.

The Chairman has served in 1978-79 as chairman of one of the two major committees in a joint AMA-Department of Health, Education, and Welfare project devoted to the production of criteria defining the necessity for surgical procedures. This long project, that has required two years to complete, will be published early in 1980. The criteria that are set forth should serve to define what has been termed "unnecessary surgery."

For some years there has been interest in the possibility that patients entering hospitals might be insured against accidents that occur during their hospital stay. The concept has been explored that would allow a certain number of "designated compensable events" to be settled immediately by a cash settlement. By taking such insurance the patient would renounce any claims to pain and suffering but would accept the sum stated as complete settlement. This concept has been explored by the American Bar Association and the Chairman of the Board of Medicine has served on their ad hoc committee that selected such designated compensable events for the field of general surgery. This report will be considered at a meeting of the American Bar Association in March 1980. At the present time it has not resulted in any action but does furnish a potential avenue for the reduction of malpractice claims especially against hospitals.

20. Medicine or Quackery

The Board has been concerned with a large number of complaints involving the practice of medicine and the determination of whether or not certain procedures that are carried out by nonphysicians constitute the unauthorized practice of medicine. For example, this Board and many other state boards have been sued by the naturopaths. The case of national importance was decided in favor of the Boards.

Other problems have developed with respect to such items as colonic irrigations, acupuncture, the treatment of obesity and hypervitamin therapy. Some of these problems have been settled by the Department of Public Health in which clinic practice has been involved. Others have led to action by our Board and in a few instances to disciplinary action. It is apparent that some of these practices have the potential of danger for patients and the public and that continued vigilance by the Board will be required.

21. Physical Therapists

The Board administered one examination for physical therapists in 1979. A total of 161 physical therapists were registered on the basis of examination. Endorsement licensure was granted to an additional 109 applicants.

Physical therapy licenses must be renewed every two years. Fifty-eight renewals were made in 1979 but the great proportion will require renewal in 1980, when approximately 3,000 renewals sill be necessary.

Rules and regulations for physical therapists require revision. This matter is on the agenda of the Board for 1980.

22. Bills Submitted by the Board for Legislative Action in 1980

The Board considered the priority items that it believes require action by the Legislature in 1980. They were introduced by Representative A. James Whitney in H-4316. The purpose of the various provisions of the bill were in brief:

a. To give the Supreme Judicial Court the exclusive jurisdiction over proceedings for judicial review of the Board's orders of disciplining a physician.

b. To accept revocation of license of a physician by another state or jurisdiction as a cause for revocation in Massachusetts.

c. To extend the Good Samaritan Act provisions to interns, medical students and temporary licensees of the Board.

d. To require hospitals to report to the Board whenever a hospital restricts, revokes or fails to renew staff privileges because of a physician's incompetence to practice medicine.

e. To require insurance companies to report to the Board any settlement or judgement of over $10,000 of a claim or actions for malpractice against a physician.

In addition, the Board supports several bills submitted by the Massachusetts Medical Society. They include (1) a bill to make the information obtained in the course of an investigation confidential until the Board has disposed of the matter by final decision (though the Board suggested amendments), (2) a bill that would allow immunity for organizations to report information concerning errant physicians to the Board, and (3) a bill that would change biennial to triennial reregistration.

23. Summary of 1979 Actions of the Board

The main accomplishments of the Board in 1979 may be summarized as follows:

a. The activation of requirements for continuing medical education as a requisite for reregistration in 1980.

b. The preparation and testing of a new reregistration form for January 1980.

c. The production of two FLEX examinations in 1979; a total of 554 candidates took the examination.

d. 1,401 new full licenses and 1,927 limited licenses were granted in FY 1979.

e. Completion of the Rules and Regulations in conjunction with the Board of Registration in Nursing covering nurses practicing in the expanded role.

f. Three hundred and sixteen complaints against physicians were received during FY I979. Counting the 133 pending complaints on 6/30/78, the Complaint Committee considered 439 cases and closed 287. At the conclusion of FY 1979 there were 152 docketed complaints that had not been concluded.

g. On January 1, 1979, there were 23 disciplinary cases pending before the Board. Ten were closed during the year; this figure included four license revocations. Since 13 new Orders to Show Cause were issued during 1979, there were 26 cases pending on January 1, 1980.

h. Submission of 5 bills to the Legislature for consideration in 1980.

24. Program for 1980

A list of the priority items for action by the Board in 1980 include:

a. Improved efficiency in the business activities of the office. The position of Executive Secretary must be filled by an individual who has both legal and administrative ability. The time required for completion of office work of all types must be shortened. More of the recommendations made by the Comptroller's Office in 1980 need to be activated.

b. Improved efficiency in disciplinary matters. The position of Counsel IV and Counsel II funded by the Legislature in 1979 are sorely needed; as of January 1, 1980, these positions had not been released.

c. Additional space is necessary for office activities.

d. Excessive expenditures for legal consultants should be reduced by using our own personnel.

There are many less concrete objectives that the Board needs to consider. They include as examples:

a. Can medicine be maintained as a profession rather than a trade? Can physicians act to police themselves and also act in the public interest? Can the Board become an essentially independent agency similar to the status accorded to the bar overseers in the Commonwealth?

b. Is it possible to assure good medical care by physicians in office practice? Today this is accomplished in a spotty fashion by (1) resolution of complaints against doctors (Suggestions have been made to a number of physicians by the Board of methods to improve their practices, and in some instances because of poor office practice Orders to Show Cause have been issued);(2) the disciplinary actions of the Board which usually have involved prescription practices without the physicians subjecting patients to proper history or physical examination; and (3) utilization review which is carried on chiefly by Blue Shield, though in cases of appeal by a physician, decisions are made by a board consisting of members appointed by the Commissioner of Insurance, the Attorney General and the Chairman of the Board of Registration in Medicine.

c. Can malpractice be prevented rather than handled after it has occurred? Since most of these episodes occur in hospitals, the Board regards several of its actions as important steps in this direction. It requires reporting of loss of privileges by physicians on their reregistration forms. A bill sponsored by the Board would make reporting of impaired physicians mandatory.

The Board has developed some of the essentials of good office medical care in the cases of the Board vs. Baer and of the Board vs. Kobrosky, of good hospital care in the Board vs. Breed, and of anesthesia in the Board vs. Masi. These legal opinions are available for study and could prove of even greater educational value if they were publicized and made available to other physicians.

d. Can confidentiality be protected in cases that are under investigation? It is clear that the Board would receive more complaints if the complainant could feel that his identity was protected. According to the Public Information Act, files of the Board are open to the public. Consequently there is immediate and serious conflict with the rights of confidentiality enjoyed by all citizens. This conflict will be difficult to resolve but some statutory solution must be found.

e. Can medical care be guaranteed for the indigent of a quality comparable to that given to the well-to-do? A quick and effective solution would be for the DPW to settle claims for Medicaid on the same fee schedules as Medicare and to modernize their reimbursement procedures. It is doubtful that any solution palatable to physicians can be achieved without this action. At present, one state has no Medicaid program; 23 states pay 91-100% of Medicare fees for Medicaid patients; 7 pay 80-90%; and 14 (including Massachusetts) pay under 80%.

25. General Survey of Medical Practice in 1979

This report concludes with a brief summary of the state of medicine in 1979. Some of the important trends include:

a. The influence of inflation and recession has had important results. Thus the drive for national health insurance slowed and financing of medical research became more difficult. Hospitals have been blamed for the major increases that have taken place in costs of medical care. A national cap on their expenditures, however, has been refused by the Congress.

b. However, a slow but steady pressure continued for some type of national insurance. Though no legislation was passed, a concept of insurance for catastrophic illness gained in popularity. The use of private insurance companies rather than government insurance also gained favor in the Congress.

c. The crisis of medical malpractice appeared to be passing. Florida and California were the only two states in which severe problems continued. Private insurance companies again are reentering the market in many states.

d. Important trends in the treatment of various diseases included:

(1) Gradual elimination of state hospitals for the care of the mentally ill. Many of those patients now have been

returned to the community. Acute care general hospitals now accept more of the seriously ill than they did before.

(2) A great increase in operations for heart disease including coronary artery bypass procedures.

(3) A greatly increased incidence of cancer of the lung particularly in women due to cigarette smoking.

(4) The increased use of computerized body scanners. Though this is an expensive method of diagnosis, its value has been fully documented, and the Nobel prize was awarded to the pioneer developers.

(5) Introduction of new drugs of which one of the most significant has been cimetidine. This has reduced the amount of hospitalization for ulcer disease significantly.

(6) Introduction of many new engineering devices into medicine. These have become so numerous that methods to regulate them have been introduced by the FDA.

e. Reduction in the number of available hospital beds. This is particularly true of municipal hospitals. Consolidation of some hospital facilities has occurred. However, some of the major hospitals are now faced with long waiting lists. Severe shortages may occur in the future.

f. There is growing belief that individuals should be more responsible for their own health. Prevention of disease and ambulatory care are removing some of the strains upon hospitals and tend to counterbalance the deficit in hospital beds.

g. Continuing medical education has continued to expand into a vast business. Innumerable courses for physicians are available. Jockeying for power has continued with the AMA and the Liaison Committee for Continuing Medical Education. Requirements of CME as a condition for reregistration of physicians is necessary in an increasing number of states. Proof that CME leads to better patient care is a matter for urgent investigation.

DISPOSITION OF COMPLAINTS RECEIVED IN FISCAL YEAR 1979 WHICH WERE NOT DOCKETED OR WHICH INCLUDED JURISDICTION OF OTHER AGENCIES OR BOARDS

TABLE I(a)

Referred	Total	No Jurisdiction	Total	Statute of Limitation	Total 9
Attorney General's Office	5	Billing	48		
Medicaid Fraud Control Unit Attorney General's Office	4	Other	25		
Dept. of Public Health Hospitals	15	Anonymous	4		
Dept. of Public Health Long Term Care	2				
Dept. of Public Welfare	2				
Diversion Investigative Unit	2				
Board of Pharmacy	4				
Board of Nursing Home Adm.	1				
Board of Nursing	4				
Dispensing Opticians	2				
Board of Optometry	4				
Health, Education, Welfare	2				
Podiatry Board	1				
TOTALS	48		77		9
				GRAND TOTAL	134 Processed

STATUS BY CATEGORY OF COMPLAINTS DOCKETED IN FISCAL YEAR 1979

July 1, 1978 - June 30, 1979

TABLE I(b)

Description	Complaints Docketed	Complaints Closed	Complaints Pending
Jurisdictional			
Negligent or Misdiagnosis	86	52	34
Sexual Involvement	3	2	1
Fraud	7	3	4
Drug Cases	7	5	2
Confirmed Alcohol or Drugs	4	0	4
Informed Consent	0	0	0
Other	46	29	17
Sub-Total	153	91	62
Questionable Jurisdiction			
Medicaid Refusal	0	0	0
Other	29	20	9
Sub-Total	29	20	9
Totals	182	111	71

COMPLAINT DISPOSITIONS - JANUARY 1, 1979 TO DECEMBER 31, 1979

TABLE II

Description	Total	Closed	Pending	Cited	Hearing	With-drawn	Informal Confer-ence	Resig-nation	Board to follow up	Otherwise Resolved
Jurisdictional										
Negligent or Misdiagnosis	66	43	23							
Sexual Involvement	4	1	3							
Fraud	9	3	6							
Drug Cases	7	1	6							
Confirmed Alcohol or Drugs	2	0	2							
Informed Consent	1	1	0							
Other	48	34	14							
SUBTOTAL	137	83	54							
Questionable Jurisdiction										
Medicaid Refusal	3	2	1							
Refusal to Complete Forms	1	1	0							
Other	20	17	3							
SUBTOTAL	24	20	4							
TOTALS	161	103	58							

TABLE V

BOARD OF REGISTRATION IN MEDICINE

Volume of Business - Registration of Physicians
(Fiscal Year 1979)

Year	1974	1975	1976	1977	1978	1979
Endorsements, National Boards	749	774	891	810	888	780
Endorsements, Other States	228	404	460	344	299	287
FLEX Examination	113	134	243	631	395	334
Total Full Registration	1155	1312	1594	1835	1582	1401
Limited Registration	2138	2564	3124	2705	2733	1927
Medical Assistants	730	361	556	-	-	-

Source: Board of Registration in Medicine-Cash Receipts

TABLE VI

(Fiscal Year 1979)

Volume of Business - Registration of Physical Therapists

Year	1974	1975	1976	1977	1978	1979
Endorsements	--	81	100	108	121	109
Examinations	180	123	140	183	196	161
Renewals	1559	109	1861	110	2249	58

Source: Board of Registration in Medicine-Cash Receipts

TABLE VII

BOARD OF REGISTRATION IN MEDICINE

Income - Fiscal 1979

Two Fiscal Periods Ending June 30, 1979

	1978	1979	Increase (Decrease)
Analysis of Receipts:			
Medicine:			
National Board - Physicians and Surgeons	$ 66,600.00	$ 67,800.00	$ 1,200.00
Endorsements - Physicians and Surgeons	22,650.00	25,475.00	2,825.00
Examinations - Physicians and Surgeons	63,250.00	56,900.00	(6,350.00)
Reexaminations - Physicians and Surgeons	20,550.00	21,300.00	750.00
Renewals	738,150.00	27,050.00	(711,100.00)
Limited Registrations - Interns	13,665.00	11,120.00	(2,545.00)
Temporary Licenses	200.00	650.00	450.00
Certified Statements	2,337.00	2,346.00	9.00
Physical Therapy:			
Examinations	9,250.00	9,220.00	(30.00)
Reexaminations	275.00	425.00	150.00
Endorsements	3,025.00	2,675.00	(350.00)
Renewals	22,490.00	740.00	(21,750.00)
Certified Statements	90.00	159.00	69.00
Miscellaneous	101.30	-	(101.30)
	$962,633.30	$225,860.00	($736,773.30)

Source: Report on the Examination of the Accounts of the Board of Registration in Medicine

BOARD OF REGISTRATION IN MEDICINE

Two Fiscal Periods Ending June 30, 1979

TABLE VIII

	1978	1979	Increase (Decrease)
Analysis of Expenditures:			
Salaries - Board Members	$ 15,700.00	$ 19,800.00	$ 4,100.00
Salaries - Permanent Employees	41,101.18	9,374.00	(31,727.18)
Services - Non-employees	44,049.10	50,750.00	6,700.90
Travel & Automotive Expenses	4,700.00	4,700.00	-
Advertising & Printing	1,311.78	-	(1,311.78)
Repairs, Replacements & Alterations	116.23	-	(116.23)
Special Supplies & Expenses	69,622.40	-	(69,622.40)
Office & Administrative Expenses	14,855.52	9,097.00	(5,758.52)
Equipment & Rentals	16,678.96	6,840.00	(9,838.96)
	$255,975.09	$100,561.00	$155,414.09
Administrative Support		187,111.00	
TOTAL EXPENSES		$287,672.00	

BOARD OF REGISTRATION IN MEDICINE

Income Versus Appropriations

TABLE IX

Fiscal Year	Income	Expenditures	Income Reverted To General Fund	%
1974	$141,906	$ 62,519	$ 79,399	55%
1975	160,684	70,398	90,285	56%
1976	847,510	154,798	691,294	81%
1977*	238,992	186,255	67,782	28%
1978*	962,647	255,989	706,658	73%
1979	225,860	287,672**	(59,879)	(25%)

*1977-1978 Comptroller's Audit - Figures were adjusted from those published in last year's Annual Report.

**Includes $187,111 administrative support

Sources: 1974-1975-1976 Board of Registration in Medicine - Cash Receipts and Budget Request FY 1978.

BOARD OF REGISTRATION IN MEDICINE

BUDGET REQUEST - FISCAL 1981

TABLE X

Subsidiary	Agency Request	Secretary Recommended	Governor's Recommendation
01	$ 46,875	$ 23,475	$ 23,475
02	107,758	122,172	122,172
03	60,000	50,000	50,000
10	11,500	7,500	7,500
11	5,650	3,500	3,500
12	400	385	385
13	135,000	135,000	135,000
14	26,605	22,000	22,000
15	1,245	1,245	1,245
16	43,000	22,500	22,500
	$438,033	$387,777	$387,777

As Submitted June, 1979

TABLE XI

THE COMMONWEALTH OF MASSACHUSETTS

ACCOUNT SUMMARY

EXPENDITURES, APPROPRIATIONS AND REQUESTS, BY ACTIVITY; FIVE YEAR PROJECTION

Consumer Affairs

ACCOUNT TITLE Board of Registration in Medicine ACCOUNT NO. 9230-0150

ACTIVITY TITLE (Indicate new activities with "N")	1979 EXPENDITURE	1980 APPROPRIATION	1981 REQUEST	Projection For Five Future Years 1982	1983	1984	1985	1986
01	19,800	22,619	46,875	50,000	50,000	55,000	55,000	60,000
02	9,374	89,496	107,758	120,000	120,000	135,000	135,000	150,000
03	50,750	50,000	53,200	55,000	60,000	65,000	70,000	75,000
10	4,700	6,000	11,500	12,000	12,500	13,000	13,500	14,000
11	DA	3,000	5,650	6,000	6,700	7,500	8,000	8,700
12	DA	350	400	400	450	500	550	600
13	DA	100,000	135,530	138,000	14,200	14,500	148,000	150,000
14	9,097	20,000	26,605	28,000	29,000	30,000	31,000	32,000
15			1,242	1,500	1,600	1,700	1,800	1,900
16	6,840	20,000	50,500	51,500	52,500	53,500	54,500	55,000
Administrative Support	187,111	44,199	44,918	45,000	45,100	45,200	45,300	45,400
ACCOUNT TOTAL (If multiple pages are required, enter these totals on final page only)	287,672	355,664	482,951	507,400	392,050	420,900	562,650	592,600
DEPARTMENTAL REVENUE ACCOUNT TOTAL	227,793	1,146,150	340,150	1,370,000	350,000	1,400,000	360,000	1,450,000
NET STATE COST	-59,879	No Cost +790,486	-142,801	No Cost +362,600	-42,050	No Cost +979,100	-202,650	No Cost +857,400

BOARD OF REGISTRATION IN MEDICINE

SUMMARY OF BOARD MEETINGS

Calendar Year 1979

TABLE XII

	Welch	Annas	Cloutier	Cassidy	Mogul	Harris	Benn	McDonough
Jan. 12		x	x	x	x	x	x	
Feb. 16	x	x	x	x		x	x	
Mar. 2		x	x	x	x	x	x	
Mar. 16	x	x	x		x	x	x	
Apr. 6	x	x	x	x			x	
May 4	x	x	x	x	x	x	x	
June 1	x	x	x	x	x	x	x	
June 22	x	x	x	x	x	x		
July 6	x	x	x	x	x	x		
Aug. 10	x		x	x	x	x		
Sept. 7		x	x	x	x	x		
Sept. 21	x	x	x	x	x	x		
Oct. 5	x	x	x	x	x			
Oct. 19	x	x	x	x	x	x		x
Nov. 9	x	x	x	x	x	x		x
Nov. 30	x	x	x	x	x	x		
Dec. 14	x	x	x	x	x			x
17	14	16	17	16	15	14	7	3

In addition, one or more Assistant Attorney General attend each meeting. Attorney Garrick Cole has been present at nearly every session, and has been continuously available for consultation.